

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 10-16-03. Dates of service 09-11-02 through 10-15-02 were not timely filed per Rule 133.308(e)(1).

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the work hardening and functional capacity evaluation on 10-16-02 through 10-28-02 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 05/02/03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 31st day of December 2003.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

Date: December 23, 2003

RE: MDR Tracking #: M5-04-0498-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic physician reviewer that has ADL certification. The Chiropractic physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

According to the supplied documentation, it appears that the claimant injured his low back on ____ while at work. The claimant was treated initially at _____. The claimant was treated with medication and released. The claimant reported to _____ on 07/05/2003 and was evaluated by _____. The claimant was also evaluated and treated by _____ on 07/09/2002, who prescribed medications. Plain film x-rays revealed postural alterations with no other significant findings on 07/11/2003. A MRI was performed on 07/18/2002, which revealed a 3-4 mm central and right paramedian disc protrusion at L4-5 with desiccation and thinning of the disc. The claimant began passive and active therapy. After a few months of therapy, the claimant underwent a work hardening program. Multiple functional capacity exams were performed. There was extensive documentation provided that was reviewed.

Requested Service(s)

Please review and address the medical necessity of the outpatient services including functional capacity exam and work hardening rendered between 10/16/2002 – 10/28/2002.

Decision

I agree with the insurance company that the work hardening services rendered between 10/16/2002 – 10/28/2002 and any FCE, within those dates, were not medically necessary.

Rationale/Basis for Decision

An initial functional capacity exam performed on 09/11/2002 reported that the claimant the claimant was at a light-medium work capacity, which was under his normal work duties of medium capacity. This would warrant the work hardening program to continue to help the claimant return to his prior duties. The second functional capacity exam performed on 10/14/2003 reported that the claimant was able to work at his prior capacity of medium duty. At that time it would be reasonable and necessary to return the claimant to the work force. The claimant had a sufficient amount of therapy to ensure that he would be able to continue his therapy at home and would no longer need the presence of a formal work hardening program. The initial 4 weeks of work hardening appears to be adequate enough to facilitate the claimant to return to his prior duties and was reasonable and medically necessary. Since the claimant was slightly under his work level (light-medium vs. medium) it appears that 4 weeks of full time therapy would be an abundant amount of therapy and under most circumstances been easily transitioned from light-medium to medium. Continued work hardening beyond the 1st 4 weeks is not considered reasonable or medically necessary in the claimant's case.